

NEW BURDENS FOR TEACHING INSTITUTIONS AND THE DOCTOR SHORTAGE *

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WHILE our subject this evening is, "The Hospitals of New York City", I shall concentrate, as my fellow speakers have, on the municipal hospital system. The reason for this attention to the municipal hospitals is very understandable. First of all, it provides the bulk of inpatient services for the sick poor and medically indigent of our community, representing about 19,000 beds and on any given day about 16,000 patients. The twenty-two municipal hospitals comprise the largest single segment of hospital care under unified control in the City of New York. What is more, the municipal hospitals, since they do not provide beds for private and semi-private patients, are more adversely affected by intern and resident shortages than even the voluntary hospitals—many of whom have also found it difficult to recruit American-trained interns and residents.

So much has been said about the medical manpower shortage, particularly in the internships and secondly in the residencies, that I will only touch upon this. Medical education has changed enormously in the last 25 years. Whereas formerly medicine was primarily a clinical art, today it is heavily infiltrated with basic science. Chemistry, physics, mathematics, electronics all have become an essential part of advanced medical practice and undergraduate and postgraduate training. To carry out these kinds of postgraduate teaching programs requires not only the physician with great clinical skill and experience, but it also requires academically trained and oriented physicians who can add to clinical skills the basic science component. At the same time the hospitals in our country have mushroomed in response to a growing population and in response to an increasing awareness on the part of the public that medicine which had talked about miracles was now doing them. These

* Presented as part of a Symposium on *The Hospitals of New York City*, held at the Stated Meeting of The New York Academy of Medicine, April 6, 1961.

changes and expansions require many more doctors than we now have. We are currently graduating as many doctors as we did 50 years ago—the result: there are in the United States each year approximately 7,000 American medical school graduates and approximately 14,000 approved internships. Every year these senior medical students critically evaluate the hospitals of our country as to the quality of their teaching program, and the hospitals of our country are being clearly divided into two groups: those which have fine teaching programs and get the American-trained students, interns and residents, and those whose training programs do not meet the needs and desires of the American graduate. Nowhere is this division seen more clearly than in the New York City municipal hospital system. Ten of our municipal hospitals not affiliated with medical schools have 242 internship positions and in the Matching Plan, which was completed several weeks ago, they *did not match one* American-trained intern. Among these are hospitals whose physical facilities are superb, like the City hospital at Elmhurst. On the other hand, Bellevue which has showered upon it the bounty of three medical schools—New York University, Cornell, and Columbia—with 98 internships matched 87 American-trained graduates. I need hardly tell you that the physical facilities at Bellevue Hospital certainly are not the reason it gets interns and residents.

Do not be taken in by the assertions that only a few more dollars are needed to attract interns and residents. This is just not so. The best hospitals with the best teaching programs often pay the least—and yet get the “cream of the crop”. This is not a plea to pay interns and residents badly. Quite the contrary, but stipends are not the solution to the problem. What then is? We in this community must shake off some of our dearly held notions about hospitals and hospitalization. It was all very well in the days when there was plenty of medical manpower and lots of nursing and other professional staff, and when hospital costs were modest, to scatter hospitals throughout the city based on geographic and demographic considerations. But today we must reckon with the hard fact that inpatient hospital care can only be adequately provided where the medical manpower is, and that the location of the medical manpower must determine the location of inpatient facilities. Where is this medical manpower? The greatest pool, of course, is in our six medical schools and the hospitals affiliated with them. The other large pool of available medical manpower devoted to quality care and teach-

ing is in the great voluntary hospitals of which New York City has more than a few. It is from these two sources that the unaffiliated city hospitals must receive the medical support essential to their operation. Wherever there needs to be rebuilding of antiquated city facilities, they must be built on the grounds of medical schools or major voluntary hospitals. Building them elsewhere is to sentence the community to poor inpatient care for many, many years. Where there are city hospital facilities of such character and location that they cannot be moved, then the medical schools and the major voluntary hospitals must strain themselves to cooperate with the municipal hospital in providing them with the medical manpower they require. This difficulty in which the unaffiliated city hospitals find themselves is no reflection on their attending staffs. For the most part the attending staffs of the municipal hospitals are well trained, highly qualified and devoted physicians, but their number has been thinning and their average age has been increasing. The necessary infusion of young, eager physicians has not been forthcoming, for these young physicians have been devoting themselves for their teaching and research to the voluntary hospitals and the medical schools which give them something important in return. I know that the medical schools affiliated with municipal hospitals have struggled for years, vexed almost beyond description by administrative inadequacies, inadequate staff and equipment, poor maintenance, and certain obsolete budgetary practices. Despite this, I am certain that in this time of need, which will become exaggerated after July 1, the medical schools, fully recognizing their community responsibility, will extend themselves to help. The voluntary hospitals in this community have already indicated they would be willing to accept larger numbers of city patients during this period, and certain voluntary hospitals have indicated their receptiveness to even more intimate ties with municipal hospitals.

I have stressed inpatient services. It is no hardship for a patient requiring inpatient care to be in a hospital 15 or 20 minutes from his home. Twenty minutes of travel is a small price to pay for the difference between high quality and poor quality medical care. Ambulatory services pose another problem. In the depressed areas of our city there is a great need for ambulatory services, and while this may be a departure from practice, I would suggest that it will be necessary and possible to continue outpatient services in a depressed area even though it may no longer be possible to maintain inpatient services. This can be

done by the assumption of responsibility for the professional services in such outpatient departments by voluntary hospitals and medical schools in the area. The closing of Gouverneur Hospital is a small but apt example of what I believe is in store for our community. There is no question that the people who were served by the inpatient facilities at Gouverneur Hospital are infinitely better off now when they are cared for by the superior services which can be rendered by the Beth Israel Hospital, the Beekman-Downtown Hospital, and Bellevue Hospital. At the same time the ambulatory services at Gouverneur are being maintained and, in fact, will be significantly improved. It is hoped that this will be accomplished by a contractual arrangement between the city and a voluntary hospital which will add its own ample staff to the existing staff of the Gouverneur Hospital and will assure provision of high level professional ambulatory service.

This need to bring together the medical schools, the voluntary hospital system, and the municipal hospital system is long overdue and will lead to a more effective and efficient use of medical manpower and physical resources. There are other steps which can and need to be taken. The Department of Health is constantly expanding its ambulatory medical services and has just recently assumed responsibility for the medical care program for the Department of Welfare recipients. We do not have the resources to develop what amounts to competing programs. It is time for the voluntary hospitals and the Department of Health and the Department of Hospitals to work out collaborative programs so that they can provide together the parallel services they now each provide separately.

It is not only the municipal hospital system that is in trouble. Quite a few of the voluntary hospitals were as unsuccessful in the matching program as the unaffiliated city hospitals. The smaller voluntary hospitals that did not get American-trained interns and residents are only slightly better off than the municipal hospitals because they deal primarily with private and semi-private patients, and the patient's physician by his own service tries to make up for the lack of an adequate house staff. Another pressing communal problem is the proprietary hospitals, some of which are adequate and accredited, but of 53 proprietary hospitals in 1958 in the New York area only 15 were accredited. It is startling to realize that almost 20 per cent of Blue Cross payments in the New York area go to proprietary hospitals. In 1958 more than 15

million dollars was paid by Blue Cross to unaccredited proprietary institutions. It is something to think about that, in the greatest city in the country, in the richest country in the world, in the center of the most advanced medical education, we find side by side the highest quality of medical care and a poor level of medical care indeed. No matter what we may successfully do by our most strenuous efforts to meet the critical situation, this July we will be facing more basic problems which must be resolved if hospital and medical care in our community and in our country is to be as good as it can be. While we are concerned with serious shortages of nursing personnel, social workers, technicians and others, the *sine qua non* of hospital and medical care is the physician. We are seriously under-doctored. The need for additional medical schools to take full advantage of our great science and to meet fully the needs of our people demands twenty more medical schools today. For years people have been talking about the need for more physicians in our country but, unfortunately, those who seem to be most knowledgeable about this and most sophisticated in medical care find themselves in medical schools and other medical care institutions which are not really feeling the pinch. The sick poor, who are the first to suffer from the shortage of physicians, are not knowledgeable enough in medical care, nor have they yet become vocal enough to have the situation corrected. We must recognize that the medical care needs we face in our country can only be effectively dealt with over the long pull by an abundance of medical manpower. Just imagine what will happen to our medical care structure when financing for the care of older persons becomes a fact. We must not only have federal help in building medical schools but we must also have federal financing for medical students. This would insure that qualified men and women can go to medical school, even if they are not fortunate enough to come from middle-class or upper middle-class families who can pay their way. It is likewise in the community's interest, if it wants doctors to be warm and devoted, not to subject them to serious fiscal deprivation during their undergraduate and postgraduate training.

In summary, it is a time for the medical schools and the voluntary hospitals to join with the municipal hospital system to provide together for the people of our community the adequate level of hospital care which they require and to which they are entitled. The city for its part must recognize the value of the contribution of the medical

schools and the voluntary hospitals and must not fiscally penalize them for their cooperation.

In this changing scene there may be the need for certain of the city hospitals to give up their functions as general hospitals and to assume specialized responsibility no less essential to the health and well-being of the community. If we do these things and the many more that our able, aggressive new Commissioner of Hospitals, Ray Trussell, is pushing for, New York City will demonstrate how municipal and voluntary agencies can together effectively meet pressing communal problems.

We must with a sense of urgency push for more medical schools now.